

OPHTHALMOLOGIC EXAM:
BOXING/MMA/KICKBOXING – page 1 of 3



Legal Name: _____ Federal/National ID#: _____
Last First Middle

Address: _____
Street City State Country

Phone: _____ E-mail: _____ Date of Birth: ____/____/____

Sex: M F Emergency Contact: _____ Emergency Telephone: _____

History -- This section is to be completed by the athlete.

Do you have or have ever been told by a doctor or healthcare provider that you have or had any of the following eye conditions, injuries, or surgeries?

	Yes	No		Yes	No
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Eye disease	<input type="checkbox"/>	<input type="checkbox"/>	Aphakia	<input type="checkbox"/>	<input type="checkbox"/>
Eye injury	<input type="checkbox"/>	<input type="checkbox"/>	Pseudophakia	<input type="checkbox"/>	<input type="checkbox"/>
Detached retina or retinal tear	<input type="checkbox"/>	<input type="checkbox"/>	Dislocated lens	<input type="checkbox"/>	<input type="checkbox"/>
Detached retina surgery	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>

Have you had LASIK, RK, or PRK surgery? If so which one? Yes No

Have you had any surgeries or procedures done to an eye or the tissues around the eye other than simple sutures of the skin around the eye? Yes No

Have you seen an eye doctor for *any* eye problem in the last 3 months? Yes No

Do you have any eye conditions or injuries from training or sparring? Yes No

If “Yes” to any of the above, explain (which eyes, nature of diseases or injuries, dates any surgeries were done):

I hereby authorize the Athletic Commission to have immediate and unlimited access to any and all medical records which may relate to my fitness to participate in boxing/mixed martial arts/kickboxing or are related to an injury or suspected injury sustained as a result of a such a match. I hereby authorize the Athletic Commission to release any and all medical information and/or personal information with respect to my status and licensure as a professional boxing/MMA/kickboxing contestant which may be contained in any of the Athletic Commission’s records. I further authorize this Athletic Commission to release this information to any person whom it determines has a need to know. I agree that I will fully cooperate with the Athletic Commission in making my medical history available including, but not limited to, giving oral or written reports to the Athletic Commission regarding my medical condition, care and/or treatment.

I attest that the answers given above are true and correct to the best of my knowledge and belief. I understand that the examining physician depends on the reliability of the statements I made above and I am not withholding any information. I further understand that all statements and information supplied by me are made under the penalty of perjury under the laws of this jurisdiction and if untrue and not informative may result in disciplinary action against my license.

 Name (printed) Signature Date

Pages 2 and 3 are to be completed by the examining physician.

OPHTHALMOLOGIC EXAM: BOXING/MMA/KICKBOXING – page 2 of 3

Name: _____ Date of Birth: _____ / _____ / _____
Last First Middle

Only a licensed and board certified physician (M.D. or D.O.) who specializes in ophthalmology may conduct this examination and complete this form. Please complete this form in its entirety.

EXAMINATION

Vision: Without/With Glasses Right _____ / _____ Left _____ / _____ Remarks: _____ _____ _____ _____	Refraction: if either eye is 20/60 or worse: Right _____ Sph _____ Cyl x _____ Acuity _____ Left _____ Sph _____ Cyl x _____ Acuity _____ Intraocular Tension Right _____ mmHg Left _____ mmHg Motility Normal _____ Abnormal _____ Binocular Vision Normal _____ Abnormal _____
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SLIT LAMP EXAM

	NORMAL	ABNORMAL	SPECIFY ABNORMALITIES
	Right/Left	Right/Left	
Conjunctiva _____	_____ / _____	_____ / _____	_____
Cornea _____	_____ / _____	_____ / _____	_____
Iris/Pupil _____	_____ / _____	_____ / _____	_____
Lens _____	_____ / _____	_____ / _____	_____
Eyelids _____	_____ / _____	_____ / _____	_____

INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated Pupil)

	NORMAL	ABNORMAL	SPECIFY ABNORMALITIES
	Right/Left	Right/Left	
Disc _____	_____ / _____	_____ / _____	_____
Macula _____	_____ / _____	_____ / _____	_____
Vessels _____	_____ / _____	_____ / _____	_____
Peripheral retina _____	_____ / _____	_____ / _____	_____
Lens _____	_____ / _____	_____ / _____	_____

POLICIES ON OCULAR CONDITIONS: *The Athletic Commission shall deny, suspend, revoke, or place restriction on the license of a boxing/MMA/ kickboxing applicant/contestant because of a medical or visual condition including but not limited to one of the following:*

1. Uncorrected visual acuity of less than 20/200 in either eye or 20/60 with both eyes.
2. Corrected visual acuity of less than 20/60 in either eye, regardless of its cause.
3. A visual field of 60 degrees or less extending over one or more quadrants of the visual field.
4. Presence or history of retinal detachment or retinal tear unless treated by an ophthalmologist and then approved by an ophthalmologist specified by the commission who then assesses that the athlete is at no significant risk of further injury to the retina if boxing/MMA/kickboxing is resumed. Such assessment shall occur both within five days before and five days after the contest.
5. Presence of primary or secondary glaucoma, whether or not such condition has been treated.
6. Presence of aphakia, pseudophakia, macular abnormalities, major lens abnormalities, or any other visual condition which would prevent the contestant from safely engaging in combative sports.
7. Presence of myopia more than -3.5 diopters in either eye.

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Name: _____ Date of Birth: _____ / _____ / _____
Last First Middle

POLICIES ON OCULAR CONDITIONS (continued)

Any of the above conditions MUST be reported immediately to the Athletic Commission. The examining physician is requested to forward a copy of any report directly to the Athletic Commission of any athlete who has a condition that may preclude him/her from safely engaging in combative sports.

REFRACTIVE SURGERY: Athletes participating in combative sports who elect to have refractive surgery need to be made aware of 1. the risks and potential complications associate with these procedures, 2. any eye injury incurred during a bout or match may result in immediate termination of the bout and transport to a medical center for ocular evaluation, and 3. licensing and clearance for an event is ultimately at the discretion of the Athletic Commission and event-specific Ringside Physician, and a history of these procedures may preclude the contestant from medical clearance.

- Radial Keratotomy (RK): Trauma can induce a corneal rupture several years after RK surgery. It takes approximately 50% less energy to rupture a cornea on an eye that has had RK versus one that has not.
- Laser-Assisted in situ Keratomileusis (LASIK): LASIK surgery is associated with a recognized increased risk of corneal injury (flap dislocation) after eye trauma. Due to the increased risk of corneal injury in combative sports athletes are discouraged from undergoing elective LASIK surgery. Athletes should be made aware of the potential complication if they decide to participate in combat sports.
- Photorefractive Keratectomy (PRK): PRK surgery does not appear to reduce corneal strength. Non-incisional refractive surgery such as PRK is preferred over incisional refractive surgery such as LASIK or RK.

CORRECTIVE LENSES: Glasses and hard contact lenses are not allowed. Soft contact lenses are permitted at the discretion of the Athletic Commission and relevant statutes and laws. Procedures for dealing with a dislodged or lost contact lens during a bout is at the discretion and direction of the Athletic Commission.

QUALIFYING STATEMENTS: These guidelines are recommendations designed to assist the practitioner as well as the Athletic Commission in making decisions. These guidelines are not intended as standards or absolute requirements, and their use cannot guarantee any specific outcome. These provide basic recommendations supported by the synthesis and analysis of current literature, expert and practitioner opinion, commentary and clinical feasibility. These recommendations may be adopted, modified, or rejected according to clinical needs and constraints and are subject to revision as warranted by evolutions of medical knowledge, technology and practice.

PHYSICIAN STATEMENT: I have read the above criteria and, in accordance with the vision requirements as stated above, have examined the named athlete. I have also reviewed the history statements made by the athlete on page 1 of this form. It is my opinion said athlete

IS IS NOT cleared to be licensed as a competitor in professional boxing/MMA/kickboxing.

If NOT please explain: _____

The athlete presented a valid form of photo I.D. and I have personally verified his/her identity.

Physician's Name, M.D./D.O.

Signature

License No.

Date

Office Address

City

State Zip

Phone

Fax